

Show me... Consumer's Guide:



MEDICARE MANAGED CARE PLANS

Missouri Department of
HEALTH



A Letter from the Director, Missouri Department of Health

Dear Missourians:

As director of the Missouri Department of Health and a physician still caring for patients, I have seen how health care decisions affect lives. These decisions have been particularly challenging during the past few years, with rapid advances in medical care and continual changes in how that care is delivered and reimbursed. Choosing a Medicare managed care plan, or determining what your plan has to offer, can be a confusing task.

That is why I am pleased to share with you this *Show me... Consumer's Guide: Medicare Managed Care Plans 2000*. This guide explains and compares the quality and availability of many of the preventive health care services offered by Missouri's Medicare managed care plans. Further, we report their members' satisfaction as well as provide useful discussions of the measures we used and clear definitions of unfamiliar terms.

In partnership with your physician, this information can help you choose the health insurance coverage that best suits you. Please take the time to use this valuable resource to its fullest.

Very truly yours,

The Missouri Department of Health has attempted to publish accurate information based upon common definitions. Managed care plans were given an opportunity to review and correct the data presented. Other corrections or suggestions should be forwarded to the Center for Health Information Management and Evaluation, Missouri Department of Health, PO Box 570, Jefferson City, MO 65102. Our telephone number is (573) 526-2812. Additional copies of this report may be purchased for \$3 each. A companion technical report, containing the data and statistical formulas used, is also available for \$10.

The Missouri Department of Health is an equal opportunity, affirmative action employer. Services are provided on a nondiscriminatory basis. This information is available in alternate formats to citizens with disabilities.

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What is Medicare Managed Care?

The *Show me... Consumer's Guide: Medicare Managed Care Plans 2000* offers information to senior Missourians on what Medicare managed care is. This guide can also help you to compare Medicare health plans in our state.

How Managed Care Works

A Medicare managed care plan is a Medicare approved network of doctors, hospitals, and other health care providers. These providers agree to give care in return for a set monthly payment from Medicare. All managed care plans are designed to control costs, manage the use of health care services and make sure these services are used effectively. Plans are also working more and more with members and doctors to prevent serious illness and promote healthy living.

In most managed care plans, you can only go to certain doctors and hospitals who have agreed to treat members of the plan. Usually you must choose a primary care physician (also called a PCP), for your doctor. Often, you can only see a specialist (like a cardiologist) when you get a referral. A referral means your PCP has approved the visit to the specialist.

Most plans also require an approval from a plan agent before going to a hospital for an operation (non-emergency), and for certain types of tests or procedures. Some specialized or experimental treatments and tests may require extra review and approval.

Senior citizens have a right to know about the services offered by Medicare managed care plans and their networks of health care doctors. It is also important to know the result of the health care these plans provide. Please use this guide as a resource to find information about the quality of Medicare managed care plans in Missouri.

Highlights of Medicare Managed Care:

- ◆ Some plans offer a Point-of-Service (POS) option which allows you to go to other doctors and hospitals who are not on the plan's list. This option generally costs you more, but gives you more choice.
- ◆ You must continue to pay the monthly Part B premium.
- ◆ Some plans charge an additional monthly premium.
- ◆ Most plans charge you a set amount (copayment), usually between \$5 and \$25 for each visit.
- ◆ You must live in the plan's service area. Non-emergency, non-urgent care outside of the United States is usually not covered.
- ◆ Typically no claims forms are needed unless you use an out-of-network doctor or provider
- ◆ You can often get extra benefits, like limited outpatient prescription drugs.

Current Plan Availability in Counties

Advantra (GHP)	Blue-Advantage 65	Coventry Advantra (KC)	HealthNet Senior Excel	Humana Kansas City	Kaiser Permanente	Medicare Complete (UHC)	Premier Plus	St. John's Premier Plus	TotalHealth Care 65
Jefferson	Cass	Cass	Cass	Clay	Cass	Franklin	Franklin	Christian	Cass
St. Charles	Clay	Clay	Clay	Jackson	Clay	Jefferson	Jefferson	Dallas	Clay
St. Louis City	Jackson	Jackson	Jackson	Platte	Jackson	St. Charles	Lincoln	Greene	Jackson
St. Louis	Platte	Platte	Platte Ray		Platte	St. Louis City St. Louis Warren	St. Charles St. Louis City St. Louis Warren	Laclede Webster	Platte

How to Use This Guide

- ◆ **Read the text and definitions**
- ◆ **Identify your plan choices**
- ◆ **Compare quality indicators**
- ◆ **Compare members' satisfaction**
- ◆ **Compare benefits and coverages**
- ◆ **Ask questions, visit websites**
- ◆ **Evaluate plans**

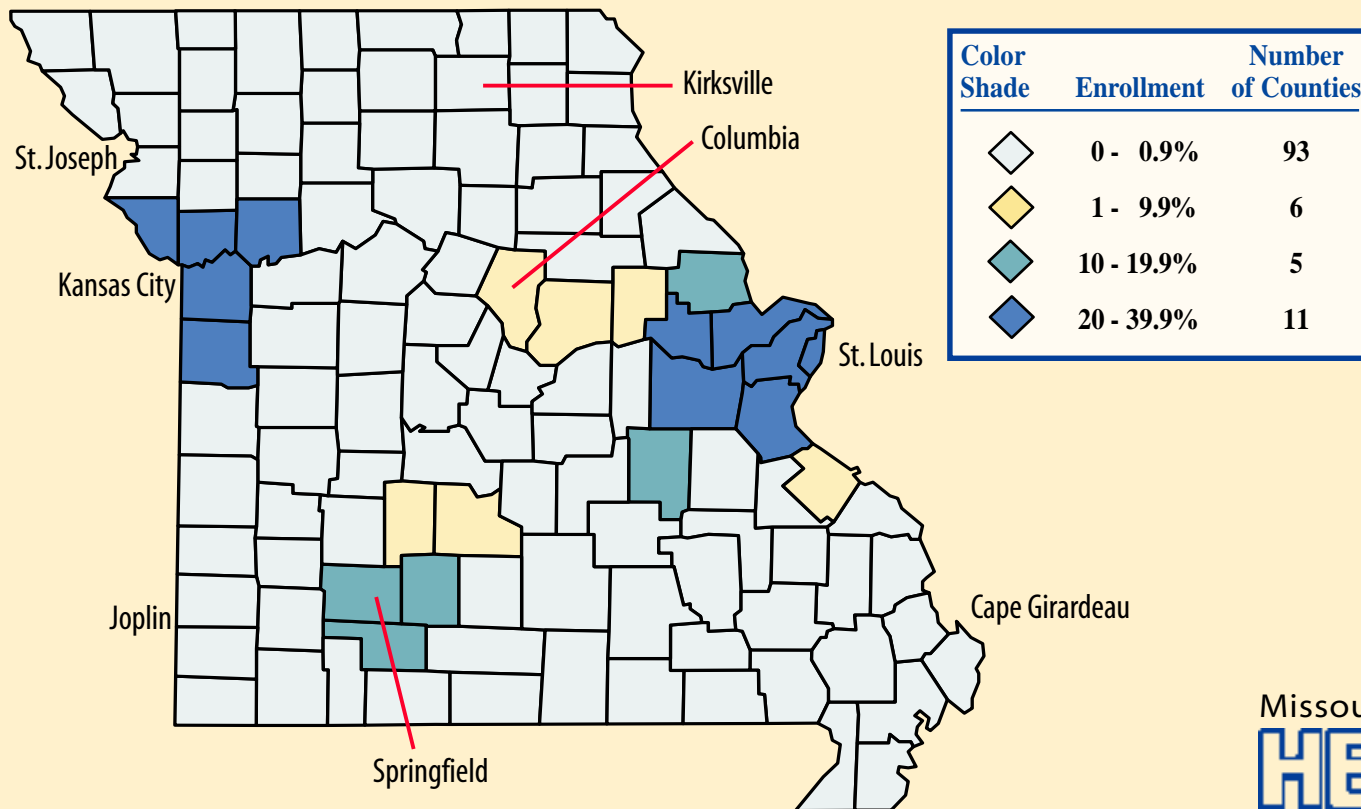
If you are already enrolled in managed care, this Consumer's Guide 2000 can help you evaluate the performance of your plan compared with other plans. If you need to make a choice between managed care plans, it can help you compare plans available in your area.

This consumer guide does not provide a simple overall ranking of the health plans. Rather, it presents different information by which you can judge the quality of managed care plans.

Definitions of many of the terms used in this guide can be found on page 28. Also provided are a number of other references and sources of information on managed care (see pages 30 and 31).

Percent of County Enrolled in Medicare Managed Care (1999)

This map shows the percent of each Missouri county's population enrolled in a Medicare managed care plan.[†] There are four different color shades representing different levels of enrollment. Most counties do not offer Medicare managed care coverage. Only 22 counties had Medicare managed care enrollment over one percent in 1999.



Missouri Department of
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[†] Population figures are U.S. Census estimates as of July 1, 1999 for 114 Missouri Counties and St. Louis City. Plan enrollment data for Medicare products available as of December 31, 1999 were obtained from the Department of Insurance. For those plans not reporting, 1998 enrollments were used. Plan availability is subject to change.

Medicare Performance Indicators

These indicators are explained in more detail on page 9.

Remember —No one indicator should be viewed as the sole measure of a health plan's performance

Performance Level

- — High Performance
- ◐ — Average Performance
- — Needs Improvement
- NA — Data Not Available

Plan Name	Breast Cancer Screening	Diabetic Eye Exam	Anti-Depression Medication Follow-Up	Beta-Blocker After Heart Attack
Advantra (GHP)	◐	○	◐	◐
Blue-Advantage 65	○	○	○	NA
HealthNet Senior Excel	●	●	◐	◐
Humana Gold Plus	◐	●	◐	◐
Kaiser Permanente	●	●	NA	NA
Medicare Complete (UHC)	◐	○	◐	◐
Premier Plus	NA	◐	NA	NA
St. John's Premier Plus	◐	●	◐	NA
Total Health Care 65	NA	○	NA	NA
Statewide Managed Care Averages	76%	46%	14%	87%
National Managed Care Averages	72%	59%	13%	87%

Breast Cancer Screening

Women (52-69) who had a mammogram (breast x-ray) in the past 2 years.

Diabetic Retinal Eye Exam

Diabetics having a retinal eye exam in the past year. Additional diabetes performance indicators can be found on page 17.

Anti-Depression Medication Follow-Up

Members with a new episode of depression, on an anti-depressant medication and had at least three follow-up practitioner visits. Other anti-depression medication indicators are on page 19.

Beta-Blockers After Heart Attack

Members who survived a heart attack and were prescribed beta-blocker medication.

The following definitions have been modified to provide concise yet professionally accurate definitions. For in-depth definitions and data collection methods please refer to the NCQA publication listed on page 27.

Anti-Depression Medication Follow-up

Percent of members prescribed an anti-depressant medication and having at least 3 follow-up practitioner contacts in the 12 week Acute Phase. Measures adequacy of treatment of members with new episodes of moderate to severe depression.

Beta Blocker After Heart Attack

Percent of members (65 or older) who were hospitalized for a heart attack and, after being discharged alive, were prescribed beta blocker medication.

Breast Cancer Screening

The percentage of women ages 52 to 69 years who had a mammogram (an x-ray of the breast) during the reporting year or the preceding year. To identify possible cancer at the earliest time, a full breast cancer screen includes mammography and a clinical breast examination where the provider checks

the breast for suspicious lumps. Women should consult with their physician to determine an appropriate time interval for breast cancer screening, based on family history and other risk factors.

Diabetic Eye Exam

The percent of diabetic enrollees who had annual retinal eye exams by a qualified eye care professional. Early detection and treatment can reduce the number of eye problems and preventable blindnesses associated with diabetes. Annual eye exams are recommended for diabetic patients.

Explanation of Scores for Performance Indicators

Medicare plans were required to submit independently audited performance rates to the Department of Health for the 1999 calendar year. For most measures, plans can choose, if needed, to improve the quality of their data using medical record review.

Statistical tests were used to assign scores of High, Average and Low for each of the performance and satisfaction indicators. These tests compare each plan rate to the average of all Medicare managed care plan rates.

Such a test can determine whether the variation seen between a plan rate and a state rate are due to chance or represent a meaningful difference. Actual rates and testing methods for each plan can be found on the Department of Health Website.

Member Satisfaction Indicators

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Courteous, Helpful Staff	Customer Service	Overall Rating of Care	Overall Rating of Health Plan
Advantra (GHP)	85%	91%	94%	97%	79%	86%	84%
Blue-Advantage 65	87	90	96	97	74	87	82
HealthNet Senior Excel	92	93	96	97	84	90	88
Humana Gold Plus	85	87	94	95	78	81	78
Kaiser Permanente	83	88	91	96	82	81	79
Medicare Complete (UHC)	85	89	93	96	84	87	85
Premier Plus	85	91	95	97	84	89	84
St. John's Premier Plus	91	92	95	98	90	90	91
Total Health Care 65	88	91	94	96	84	89	89
Statewide Averages	87%	90%	94%	97%	82%	87%	84%
National Averages	85%	89%	94%	96%	69%	87%	81%

Getting Needed Care Getting Care Quickly

Health plans and providers work together to provide appropriate and needed treatment. This includes the ability to get health plan approval and referral to a specialist without delay.

Satisfaction Level

Numbers above show the percent of highly satisfied members in each satisfaction area.

How Well Doctors Communicate Courteous, Helpful Office Staff Customer Service

Physicians with effective methods of interaction, discussion and listening, are better able to identify problems and address health needs and concerns. Caring and considerate clinic personnel can also help reduce patient discomfort and anxiety. Effective service and good information alleviate needless worry and frustration.

Overall Rating Health Care Overall Rating Health Plan

Delivery of quality health care is a partnership between plans and their network of providers. Health plan satisfaction includes quality of care as well as non-medical issues such as locations, hours and customer service.

These indicators are explained in more detail on page 11.

How Satisfied Members Are With Their Managed Care Plan in the Last Six Months

Detailed below are the member satisfaction questions that make up each of the composite and single question indicators on page 10. Responses bolded in blue were used as the high satisfaction responses.

Getting Needed Care

A big problem, A small problem, **NOT A PROBLEM**

- ◆ From the choices your health plan gave you, did you get a personal doctor or nurse you are happy with?
- ◆ Did you get a referral to a specialist that you needed to see?
- ◆ Did you get the care you or a doctor believed necessary?
- ◆ Were there delays in health care while you waited for approval from your health plan?

Getting Care Quickly

Never, Sometimes, **USUALLY, ALWAYS**

- ◆ When calling during regular office hours, did you get the help or advice you needed?
- ◆ Did you get an appointment for regular or routine health care as soon as you wanted?
- ◆ Did you get care as soon as you wanted when care was needed right away?
- ◆ Did you wait in the doctor's office or clinic [no] more than 15 minutes past your appointment time to see the person you went to see?

How Well Doctors Communicate

Never, Sometimes, **USUALLY, ALWAYS**

- ◆ Did doctors listen carefully to you?
- ◆ Did doctors explain things in a way you could understand?
- ◆ Did doctors have respect for what you had to say?
- ◆ Did doctors spend enough time with you?

Courteous, Helpful Office Staff

Never, Sometimes, **USUALLY, ALWAYS**

- ◆ Were you treated with courtesy and respect?
- ◆ Did you receive the help you needed?

Customer Service

A big problem, A small problem, **NOT A PROBLEM**

- ◆ Could you understand the information in the written materials?
- ◆ Could you call for help from your health plan's customer service?
- ◆ Could you complete the paperwork for your health plan?

Overall Rating: Health Care

1 2 3 4 5 6 7 **8 9 10**
Worst BEST

- ◆ Rate health care received from all doctors and other health care providers?

Overall Rating: Health Plan

1 2 3 4 5 6 7 **8 9 10**
Worst BEST

- ◆ Rate your overall experience with your Medicare managed care plan?

Screening, Case Management and Educational Materials for Selected Conditions

Plan Name	Women's Cancer			Cardiovascular			Respiratory		
	Breast (B), Cervical (C), Ovarian (O)			Obesity (O), Stroke (S) Congestive Heart Failure (H)			Asthma (A), Tobacco Use (T) Chronic Obstructive Lung Diseases(L)		
	Screening	Case Management	Educational Materials	Screening	Case Management	Educational Materials	Screening	Case Management	Educational Materials
Advantra (GHP)	BC	BCO	BCO	SH	SH	OH	ALT	AL	ALT
Blue-Advantage 65	BC	BCO	none	SH	OSH	H	ALT	ALT	ALT
HealthNet Senior Excel	none	BCO	B	H	SH	H	AL	AL	AL
Humana Gold Plus	BCO	none	BCO	SH	SH	OH	T	LT	T
Kaiser Permanente	BCO	none	BCO	OSH	H	OSH	AT	A	ALT
Medicare Complete (UHC)	BC	BCO	BC	SH	SH	SH	AL	ALT	ALT
Premier Plus	B	none	BCO	S	SH	SH	A	AL	ALT
St. John's Premier Plus	none	none	none	none	SH	none	none	AL	none
Total Health Care 65	BC	BCO	none	SH	OSH	H	ALT	ALT	ALT

For each of these conditions...

Screening

Did the managed care plan provide screening mechanisms such as clinical evaluations or tests that can detect these diseases early?

Case Management

Did the managed care plan provide case management? Case managers work with patients, providers and physicians to coordinate the medical care that patients with complex or chronic illnesses need to receive. Case managers help patients take care of themselves and make sure they get the right specialists, equipment and medications.

Educational Materials

Did the managed care plan provide health promotion and other educational materials for persons at risk for these conditions? These materials include information on the condition, controlling it, and maintaining a healthy lifestyle.

Health Facts

Women's Cancer ^{5,6,7,8}

Breast Cancer is a greater risk for women over the age of fifty. Smoking, having a family history of cancers or having certain genetic mutations also add to the risk of getting breast cancer. When the cancer remains localized due to early detection, the 5-year survival rate increases to 97% for women overall.

Cervical Cancer: If every woman had an annual Pap test, cervical cancer would be nearly eliminated. A related disease, cancer of the uterus, is a greater risk for women over age 50, especially if they are obese.

Ovarian Cancer is the sixth most common cancer (other than skin cancer) in women, ranking fifth in causes of death. There is a peak chance of getting ovarian cancer in a woman's mid-50s, with rates increasing more slowly after that.

Note: Superscripts refer to websites where you can get more information on these conditions. See page 30 for the Internet addresses of these websites.

Cardiovascular ^{2,3,4,8}

Obesity can place you at risk for heart disease or stroke, diabetes, sleep apnea, osteoarthritis and gallbladder problems. In women, it increases the risk of cancer of the uterus, cervix, ovary, breast, gallbladder and colon. For men, obesity increases the risk of colon, rectum and prostate cancer.

Stroke: Every year approximately 730,000 Americans have a new or recurrent stroke. Approximately one-third of all stroke survivors will have another stroke within five years. Stroke is our nation's third leading cause of death, killing nearly 160,000 Americans every year.

Congestive Heart Failure: Up to 3 million Americans have heart failure, and 400,000 new cases are diagnosed each year. Slightly more men than women have this condition and it is twice as common among African Americans as whites. The condition affects 1 percent of people age 50, but about 5 percent of people age 75.

Respiratory ^{1,2,8}

Asthma affected 17 million Americans in 1998. Generally, people with asthma can and should exercise when they feel well. Always consult your physician before starting any type of regular exercise. Many people with asthma do not know they have it.

Chronic Obstructive Lung Disease also called chronic obstructive pulmonary disease (COPD) includes two closely related lung diseases: chronic bronchitis and emphysema. Most patients with these diseases have a long history of heavy cigarette smoking. Other risk factors for COPD include age, heredity, exposure to air pollution at work and in the environment, and a history of childhood lung infections.

Tobacco Use: Cigarette smoking is responsible every year for approximately 130,000 deaths from cancer, 170,000 deaths from heart disease, and 50,000 deaths from lung disease.

Prevention Services

Plan Name	Physician Practices Updates	Feedback on Preventive Services	Pre-/Post-Surgery Information	Reminders			
				Breast X-ray	Well Woman Exams	Immunizations	Diabetic Tests
Advantra (GHP)	●	●	●	●	●	●	●
Blue-Advantage 65	○	●	●	●	●	●	●
HealthNet Senior Excel	○	○	○	●	○	●	○
Humana Gold Plus	○	●	●	●	●	●	●
Kaiser Permanente	○	○	●	●	●	●	●
Medicare Complete (UHC)	●	●	●	●	●	●	●
Premier Plus	●	●	○	●	●	○	●
St. John's Premier Plus	○	●	○	○	○	○	○
Total Health Care 65	○	●	●	●	●	●	●

Physician Practices Updates

Did plan conduct activities for their providers on improving current clinical practices?

Feedback on Prevention Services

Did plan emphasize preventive services by providing feedback to physicians on their use of these services with the plan's members.

Pre-/Post-Surgery Information

Did plan offer pre- and post-surgery information to members covering:

- ◆ pre-/post-surgery diets?
- ◆ normal versus warning symptoms after surgery?
- ◆ possible side effects or interactions among surgery related prescriptions, especially pain-killers?

Reminder Calls or Letters

Were reminder letters or phone calls used to promote preventive services:

- ◆ mammogram (breast x-ray)?
- ◆ well woman exams?
- ◆ immunizations?
- ◆ diabetic tests?

Provide Service?

- — Yes
- — No

Selected Plan Benefits Offered to Members and Referral Policies

Plan Name	Chiropractic Services	Eye Exam Refractive Errors	Smoking Cessation	Podiatrist Services	PCP for Referral to Any Specialist	GYN Without Referral	No Prior Authorization Needed for Specialist	Specialist as PCP for Chronic Conditions
Advantra (GHP)	●	●	○	●	◐	○	○	○
Blue-Advantage 65	◐	●	○	◐	●	●	○	●
HealthNet Senior Excel	●	◐	○	●	◐	○	◐	◐
Humana Gold Plus	◐	●	●	●	◐	●	◐	○
Kaiser Permanente	●	●	○	●	●	●	◐	○
Medicare Complete (UHC)	●	●	○	●	◐	●	○	○
Premier Plus	◐	●	◐	●	◐	○	○	●
St. John's Premier Plus	◐	●	◐	●	◐	○	○	●
Total Health Care 65	◐	●	○	◐	●	●	○	●

Benefits Offered

Did the managed care plan offer the following benefits to its members?

- ◆ Chiropractic Services, often for Short Term Therapy
- ◆ Eye Exams for Correcting Vision with Refractive Errors
- ◆ Smoking Cessation Classes or Medication
- ◆ Podiatrist Services

Benefits & Policies Offered?

- — All Products
- ◐ — Some Products[†]
- — No Products

[†] Contact plan to determine specific policy

Plan Referral and Prior Authorization Policies for Specialists

Did the plan require the patient to see their primary care physician (PCP) for referrals to any specialists?

Did the plan allow access to:

- ◆ Gynecologists (GYNs) without a referral other than the well woman visit once per year?
- ◆ In-network specialists (non-GYNs) without referral or prior authorization?
- ◆ Specialists as the primary care physicians for chronic conditions?

Medicare Preventive Services

These preventive services (services to help you stay healthy) are covered by Medicare managed care under Part B eligibility:

◆ **All beneficiaries.**

Vaccinations

Flu shot: Yearly (Oct.-Jan.).

Pneumococcal Vaccination: One may be all you ever need—ask your doctor.

Hepatitis B Vaccination: If you are at high risk for hepatitis.

◆ **All beneficiaries age 50 and older.**

Colorectal Cancer Screening

Fecal Occult Blood Test: Once every year.

Flexible Sigmoidoscopy: Once every four years.

Colonoscopy: Once every two years if you are high risk for cancer of the colon.

Barium Enema: Doctor can substitute for sigmoidoscopy or colonoscopy.

◆ **All female beneficiaries.**

Pap Smear and Pelvic Examination:

(Includes clinical breast exam) Once every three years. Once per year if you are high risk for cancer of the cervix or had an abnormal pap smear in the preceding three years.

◆ **All female beneficiaries age 40 and older.**

Screening Mammogram: Once per year.

◆ **All diabetic beneficiaries (insulin users or non-insulin users)**

Diabetes monitoring: Includes coverage for glucose monitors, test strips, lancets, and self management.

◆ **Certain beneficiaries at risk for losing bone mass.**

Bone Mass Measurement: Varies with health status.

Starting Jan. 1, 2000, Medicare coverage for prostate cancer screening includes digital rectal exam and Prostate Specific Antigen (PSA) Test, once per year

Plan Name	HbA1c Tested	Poor HbA1c Control	Nephropathy Monitoring	Diabetes Screening	Diabetes Case Management	Diabetes Educational Materials
Advantra (GHP)	●	●	●	Yes	Yes	Yes
Blue-Advantage 65	○	●	●	Yes	Yes	Yes
HealthNet Senior Excel	●	○	●	No	Yes	No
Humana Gold Plus	●	●	●	Yes	No	Yes
Kaiser Permanente	●	●	●	Yes	Yes	Yes
Medicare Complete (UHC)	●	NR	○	Yes	Yes	No
Premier Plus	●	NR	○	No	Yes	Yes
St. John's Premier Plus	●	NR	○	No	Yes	No
Total Health Care 65	○	○	○	Yes	Yes	Yes
Statewide Averages	73%	26%	32%	67%	89%	67%
National Averages	78%	35%	38%	—	—	—

Performance Level

- — High Performance
- — Average Performance
- — Low Performance
- NR — Data Not Reported or Unusable

HbA1c Testing

Percentage of diabetics who had their hemoglobin A1c tested at least once in the past year. A hemoglobin A1c test measures the average amount of sugar in the blood during the past 3 months.

HbA1c Control

Percentage of diabetics whose most recent hemoglobin A1c tested greater than 9.5%. (Note: High rating indicates good control of less than 9.5%)

Monitoring Nephropathy

Percentage of diabetics who were monitored for kidney disease (nephropathy).

Screenings/ Case Management/ Educational Materials for At-Risk Patients

- ◆ Did the managed care plan provide screening mechanisms?
- ◆ Did the managed care plan provide case management?
- ◆ Did the managed care plan provide health promotion and other educational materials for persons at risk for diabetes?

You should write down any questions you have and take them with you to each visit to your doctor.

Spotlight on. . . Diabetes (cont.)

Type II diabetes is a disorder of the glucose (sugar) metabolism. This type of diabetes, is often preventable. More than 85% of people developing Type II diabetes are overweight and symptoms generally show up later in life. The best way to prevent diabetes is to keep your weight down, eat a healthy diet, and exercise. If you are diabetic, many types of pills can now control diabetes, often without needing insulin injections.^(3, 8,9,10)

Be Aware: Diabetes is on the rise due to recent increases in obesity among the U.S. population.

Get tested for diabetes if you:⁽⁸⁾

- ◆ are 45 or older
- ◆ have diabetes in your immediate family
- ◆ are overweight
- ◆ had diabetes in pregnancy
- ◆ have hypertension
- ◆ have high cholesterol or triglycerides
- ◆ belong to a high-risk racial/ethnic group (eg. African-American, Hispanic, Native American, Asian-American)

Once you have diabetes, the best way to manage it and prevent complications is to:⁽³⁾

- ◆ take prescribed diabetes medicine
- ◆ test blood sugar often, control it quickly
- ◆ keep a record of tests, daily events, and medicines
- ◆ ask for a hemoglobin A1c test, 2 or more times per year or every 3 months if your blood sugar is high
- ◆ get regular checks of blood pressure, cholesterol and blood fats
- ◆ check feet daily; have eyes and kidneys checked at least once a year
- ◆ see a dentist, at least twice a year
- ◆ get regular physical activity
- ◆ develop and stay on a good meal plan; avoid junk food

Links —

³ National Institute of Diabetes and Digestive and Kidney Diseases
www.niddk.nih.gov/health/nutrit/win.htm
 (800) 946-8098

⁸ American Medical Association
www.ama-assn.org

⁹ National Diabetes Educational Program
www.ndep.nih.gov
 (800) 438-5383

¹⁰ Centers for Disease Control and Prevention
www.cdc.gov/diabetes
 (877) 232-3422

Spotlight on. . . Depression

Plan Name	Effective Acute Phase Treatment	Effective Continuation Phase Treatment	Depression Screening	Depression Case Management	Depression Educational Materials
Advantra (GHP)	●	●	Yes	No	No
Blue-Advantage 65	●	●	Yes	Yes	No
HealthNet Senior Excel	●	●	No	Yes	No
Humana Gold Plus	●	●	Yes	Yes	No
Kaiser Permanente	NA	NA	Yes	Yes	Yes
Medicare Complete (UHC)	○	○	Yes	Yes	Yes
Premier Plus	NA	NA	No	Yes	Yes
St. John's Premier Plus	●	●	No	No	No
Total Health Care 65	NA	NA	Yes	Yes	No
Statewide Averages	55%	38%	67%	78%	33%
National Averages	55%	39%	—	—	—

Performance Level

- — High Performance
- — Average Performance
- — Low Performance
- NA — Data Not Available

Effective Acute Phase Treatment

Percentage of members with a new episode of depression, on anti-depressant medication and who remained on medication during the entire 84-day Acute Treatment Phase.

Effective Continuation Phase Treatment

Percentage of members with a new episode of depression, on anti-depressant medication and who remained on medication at least 180 days.

Screening/Case Management/Educational Materials for At-Risk Patients

- ◆ Did managed care plan provide screening mechanisms?
- ◆ Did managed care plan provide case management?
- ◆ Did managed care plan provide health promotion and other educational materials for persons at risk for depression?

Depression is a complex "whole body" illness affecting physical health as well as how a person feels, thinks and behaves toward others. Several types exist: Adjustment Disorder, Chronic and Major Depression, Manic-Depressive Illness. Causes include biochemical changes in the brain, family heredity or personality. Stressful events such as the death of loved ones, family relations, financial problems, or even "winter blues" may also trigger depression.

Spotlight on. . . Depression (cont.)

Everyone is at risk for depression. Nearly 10% of Americans are affected by some form of depression, over half having major or clinical depression. Older people are among the three most susceptible groups. Depression's disabling moods can damage personal and family relationships and cause isolation or rage. Fifteen percent of all people with major depression will end up taking their own lives. The highest suicide rates are for single or widowed Caucasian males over age 55.

If you are diagnosed with depressive illness many medicines can now control it. Unfortunately, minor tranquilizers and sleeping pills are prescribed twice as often as the correct medication. But even when given the right drug, dosages are frequently lower than needed to get the best results. Other steps can assist in speeding recovery from depression and help keep it from returning. ^(8,11,12,13)

Be Aware: Suicide is most likely to occur when things seem to be getting better.

Things you can do for yourself are: ^(8, 12, 13)

- ◆ reduce stress
- ◆ socialize
- ◆ exercise or be physically active
- ◆ learn stress management techniques
- ◆ set realistic, reachable goals
- ◆ get nutritional advice & eat healthy foods

Things to help a depressed friend are: ^(8, 12, 13)

- ◆ offer reassurance, be comforting
- ◆ encourage getting professional help
- ◆ don't criticize or judge
- ◆ don't be easily pushed away
- ◆ encourage healthy habits
- ◆ encourage socializing
- ◆ don't encourage overcommitment
- ◆ don't ignore remarks about or threats of suicide

Links —

- ⁸ American Medical Association
www.ama-assn.org
- ¹¹ National Foundation For Depressive Illness, Inc.
www.depression.org/symptoms.html
(800) 239-1265
- ¹² National Institute of Mental Health
www.nimh.nih.gov
(301) 443-4513
- ¹³ Medline Plus Health Information - Depression
www.nlm.nih.gov/medlineplus/depression.html

Choosing a Managed Care Plan

If you decide to join a Medicare managed care plan remember — you are still in the Medicare program with all its rights and protections. You continue to get all your regular Medicare covered services. Still, choosing a managed care plan can be complex and difficult. Follow these helpful steps to make it easier.

- ◆ Identify all plans which offer coverage in your area by calling the Community Leaders Assisting the Insured of Missouri (CLAIM) program at 1-800-390-3330 or 1-573-893-7900.
- ◆ Review the indicators in this booklet only in combination. No one indicator should be viewed as a sole direct measure of a health plan's performance.
- ◆ Come up with your own questions and call your plan choices for answers using the phone numbers in the back. Plans can provide you a member handbook of benefits plus a list of doctors and hospitals in their Medicare network.
- ◆ Contact CLAIM for a health plan comparison worksheet and other Medicare information.
- ◆ Talk to your doctor, family and friends about their experiences with managed care.
- ◆ Use all information to evaluate your managed care options. Make the choice that best suits your need.

Will My Out-of-Pocket Costs Change With Managed Care?

Your costs will depend upon:

- ◆ Whether the plan charges a premium in addition to the monthly Part B premium (\$50.00 in 2001).
- ◆ The type of health care you need and how often you get it.
- ◆ How much the plan charges per visit, such as a \$5 or \$10 copayment every time you see your doctor (in place of the 20% coinsurance charged in Original Medicare).
- ◆ How much the plan charges for extra benefits.
- ◆ Whether you get health care outside the service area of the plan (except in an emergency).

Sample Questions for Managed Care Plans

In addition to the information provided in this guide, you should also ask the plan the following types of questions:

1. Is my current practitioner a part of the managed care plan's network? Will I be able to see the same primary care doctor all of the time?
2. I am under the care of a specialist — is he or she part of the plan's network? Does the plan require prior authorization for specialty care? Is it possible to receive services from a specialist not affiliated with my managed care plan?
3. What extra preventive services does the plan offer (e.g. physical exams, immunizations)?
4. How and where do I obtain after-hours care?
5. How do I receive care if I am out of town or in another state? What will be the cost of this care?
6. How are complaints or grievances handled?
7. Does the plan offer translation services if needed?
8. What are my premium costs? Co-payments?
9. What specialized hospitals are in the plan's network?
10. Are all outpatient prescription drugs covered?

Can I Keep my Medigap Policy If I Join a Managed Care Plan?

If you join a Medicare managed care plan, you may keep your Medigap policy (but you can't use it unless you return to the Original Medicare Plan). If you drop your Medigap policy, you may have the right to get another Medigap policy later if:

- ◆ You lose your Medicare managed care plan coverage (through no fault of your own), or
- ◆ You join a Medicare managed care plan for the first time, and within one year of joining, you decide you want to leave managed care. If you were new to Medicare when you joined the plan, you may be able to choose any Medigap policy you want. If you already had a Medigap policy before you joined the plan, you may be able to re-enroll in the same policy as before.

Need More Information about Medigap?

Contact the Missouri CLAIM program at:
1-800-390-3330

Before You Join a Medicare Managed Care Plan, keep in mind that...

- ◆ Managed care plans are offered by private companies. Each year they can change the extra benefits they offer and how much they charge. The plans must tell you about these changes in advance.
- ◆ When managed care plans sign a contract with Medicare, they agree to stay for at least one calendar year. Each year, they make a business decision to stay with or leave the Medicare program.
- ◆ Doctors can join or leave managed care plans at any time.
- ◆ Managed care plans may charge an extra monthly premium, in addition to your monthly Part B premium.
- ◆ Some managed care companies limit the number of members in their plans. These plans may not accept new members all of the time. A company can tell you if a plan has reached its limit or is still signing up new members.

To Join a Managed Care Plan...

1. Call the plan and request an enrollment form.
2. Fill out the form and mail it to the plan.
3. You will get a letter telling you when your coverage begins.

Note: During the month of November, Medicare managed care plans (with some exceptions) must accept new members. If you join in November, your coverage begins on January 1.

Know Your Medicare Rights

You have guaranteed Medicare rights even when you are covered under a Medicare managed care plan. These rights protect you when you get health care. They assure you access to needed health care services and they protect you against unethical practices.

As a Medicare beneficiary you have the right to:

- ◆ see your primary care provider
- ◆ choose a women's health specialist
- ◆ receive specialty care that is medically necessary
- ◆ receive urgent, after-hours and emergency care
- ◆ information about all treatment options available to you
- ◆ access to health care providers without unreasonable distances to travel or lengthy delays
- ◆ access to specific preventive services at medically appropriate times
- ◆ see your medical records
- ◆ privacy about your medical condition
- ◆ protection from discrimination in marketing and enrollment practices
- ◆ know how your Medicare health plan pays its doctors
- ◆ information about what is covered and how much you have to pay
- ◆ not be charged or billed by network providers for covered services that managed care plans fail to pay
- ◆ appeal decisions to deny or limit payment for medical care

For **FREE** help when your Medicare rights have been violated, call **Community Leaders Assisting the Insured of Missouri (CLAIM)**. The CLAIM number is **1-800-390-3330**.

Know Your Responsibilities

Know the rules of your managed care plan before you use medical services.

You have a responsibility to:

- ◆ select a regular medical provider
- ◆ schedule appointments and keep them, or call to cancel
- ◆ read materials given to you and ask questions about anything you do not understand
- ◆ make sure that you follow the rules of your managed care plan about referral to other providers before seeing other medical providers (you may have to pay the bill if you see a specialist without a referral)
- ◆ be prepared to show your membership card and pay co-insurance and co-payments at time of visit or make arrangements for timely payment
- ◆ live a healthy lifestyle by being physically active and eating right

What Do Medicare Managed Care Plans Look Like?

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Plan Name	Licensee Name	1999 Medicare Enrollment	1998-1999 Change in Enrollment	1999 Statewide Market Share
Advantra (GHP)	Group Health Plan Inc.	25,960	10%	22%
Blue-Advantage 65	Good Health HMO Inc.	5,531	3	5
Coventry Advantra [†]	Coventry H.C. of Kansas, Inc.	658	new	1
HealthNet Senior Excel	Health Net Inc.	8,960	24	7
Humana Gold Plus	Humana Health Plan Inc.	15,322	- 13	13
Kaiser Permanente	Kaiser Foundation Health Plan of KC	2,931	3	2
Medicare Complete (UHC)	UnitedHealthcare of the Midwest Inc.	48,063	11	40
Premier Plus/St. John's Premier Plus	Mercy Health Plans of Missouri Inc.	5,986	27	5
Total Health Care 65	Blue Cross/Blue Shield of Kansas City	1,350	N/A	1
Average of All Plans		113,411 ^{††}	9%	

Licensee

Financial and enrollment information in this table was supplied by the Department of Insurance (DOI). Health plans are only required to report to DOI at the licensee level so not all separate products found on prior tables were available. Where 1999 data were incomplete or not reported, 1998 data were used.

Medicare Enrollment

Figures indicate how many Missourians were enrolled in a Medicare managed care plan in 1999. There are strengths and limitations relative to a plan's size. Larger plans may be able to spread the risk of high medical expenses across a bigger population to avoid impacting their overall financial strength. Smaller plans may be able to respond more quickly to consumer requests.

Percent Change in Medicare Enrollment

Year 1999 and 1998 changes are shown. Changes can result from several events such as withdrawals from unprofitable areas, entry into new markets or mergers of health plans.

Statewide Commercial Market Share

This shows the percentage of the State's medicare managed care plan members who are enrolled with a specific plan. It provides an indication not only of plan size but also of the population size over which plan risk is spread for medical services. Especially when compared to enrollment and other satisfaction or quality indicators, this measure can reflect a plan's success in meeting the varied health care needs of the State's citizens.

[†] This is a new plan offering for 1999.

^{††} This is a total enrollment for these plans.

What Do Medicare Managed Care Plans Look Like? (cont.)

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Plan Name	1999 Accreditation	1997-1999 Complaint Index ^{††}	1997-1999 Days in Unpaid Claims ^{††}	1997-1999 Medical Expense Ratio ^{††}	1997-1999 Administrative Expense Ratio ^{††}
Advantra (GHP)	none	○	●	92%	●
Blue-Advantage 65	URAC	●	●	88	●
Coventry Advantra [†]	new	○	●	85	●
HealthNet Senior Excel	none	●	○	87	●
Humana Gold Plus	NCQA	●	●	85	●
Kaiser Permanente	NCQA	●	●	93	●
Medicare Complete (UHC)	URAC & JCAHO	●	●	85	●
Premier Plus/St. John's Premier Plus	none	●	●	95	●
Total Health Care 65	URAC	NA	NA	73	●
Average of All Plans		82	47	89%	13%

Performance Level

- — High Performance
- — Average Performance
- — Low Performance
- NA — Data Not Available

Accreditation Status

Accreditation is voluntary and indicates plans meet national quality standards from indicated national organizations. (see page 28) For more information about a plan's level of accreditation check their website.

Complaint Index

Compares the industry average of the number of consumer complaints in the past three years relative to the amount of business a company writes in Missouri. Plans at less than 50% of industry average shown as high performance; more than 100% of industry average shown as low.

Days in Unpaid Claims

How long it takes to pay benefits and other bills is important because it tells how long providers have to wait to get paid. High performance is less than 45 days, average performance is 45-59 days, low performance is 60 days or more.

Medical Expense Ratio

Percentage of total premiums and related revenues that covers total medical and hospital expenses. A ratio that is too high can mean the plan may not be making sufficient profit to stay in business. Too low a ratio may mean the plan is not spending enough revenues on medical and hospital expenses. Ratios of 85% to 95% can be considered typical, although a new plan starting up may have a lower ratio.

Administrative Expense Ratio

Percentage of total revenue used for administrative overhead, an indicator of "efficiency." Plans with expenses less than 16% are high performers. Expenses between 16% and 26% are average but 26% or more is considered low performance.

[†] This is a new plan offering for 1999.

^{††} This is a company-wide measure and does not derive solely from the Medicare health plan.

Where We Get Information

Much of the information in this booklet comes from the Health Care Financing Administration (HCFA). HCFA administers Medicare, the nation's largest health insurance program. In Missouri, this agency insures 850,000 lives with about 110,000 enrolled in managed care. HCFA oversees the

- ◆ HEDIS® data submitted by Missouri managed care plans and audited by independent, licensed firms.
- ◆ Member satisfaction surveys developed by NCQA and conducted by WESTAT, an independent survey firm.
- ◆ National averages from Medicare Public Use Files.

Other information sources include:

- ◆ Financial data collected by the Department of Insurance.
- ◆ Enrollment and complaint data supplied by the Department of Insurance.

References:

Medicare Patient Rights. HCFA Publication No. HCFA-10112

Your Medicare Benefits. HCFA Publication No. HCFA-10116 rev. May 1999

Medicare and You 2001. HCFA Publication No. HCFA-10050 rev. Sept. 2000

Understanding Your Medicare Choices. HCFA Publication No. HCFA-10120 rev. June 1999

Healthy People 2010. Department of Health and Human Services (Conference edition, in two volumes)
Washington, D.C.: January 2000.

Missouri Health Maintenance Organization Report 1999. Missouri Department of Insurance, Managed Care Section, pending publication.

National Committee for Quality Assurance. HEDIS® 2000. Washington DC: NCQA, 1999.

U.S. Preventive Services Task Force. Guide to Clinical Preventive Services, 2nd ed. Baltimore: Williams & Wilkins, 1996.

What We Mean When We Say . . .

Definitions of terms are provided here to help consumers understand concepts used in this guide.[†]

Access to Care

Access is the members' ability to obtain medical services from their health plan. Access includes, among other things: benefits and preventive care offered, referral policies, clinic or hospital location and their hours of operation.

Accreditation

Three national organizations accredit health plans in Missouri: the National Committee for Quality Assurance (NCQA), the American Accreditation Healthcare Commission/ Utilization Review Accreditation Commission (URAC), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Accreditation is important because it indicates a health plan has met national quality standards.

Fee-for-Service

A traditional health insurance system where the insurer pays the provider for each service provided to the insured person or member.

HEDIS®

Health Plan Employer Data and Information Set (HEDIS®) is a set of performance measures, or indicators, developed to assist in understanding the accountability and value of individual health plans.

Indicator

A performance indicator describes a measurable aspect of health care delivery that can be compared with clinically valid criteria to see if a health plan meets national quality standards. Collectively, indicators provide an idea of quality and appropriateness of care delivered, and the members' satisfaction with care received.

Managed Care

A system of health care where a defined group of providers shares financial risk or has incentives to deliver high quality, cost-effective services to an enrolled population. This type of health insurance typically focuses on managing the use of services, controlling costs, and monitoring the performance and outcomes of health care delivery.

Member Satisfaction

Satisfaction with a health plan is an important dimension of quality from a member's perspective. A patient's experience with the health care professional clinic staff, and plan's administrative staff and policies can enhance or diminish the medical treatment received.

(cont. on page 29)

[†]Many definitions on this page adapted from Managed Care Glossary 2000, Family Health Partners, Kansas City, MO.

What We Mean When We Say . . . (cont.)

Network of Providers

A defined group of providers, physicians and hospitals who contract with a managed care organization to provide health services to the plan's members.

Preauthorization

In an HMO, the member usually must notify the health plan prior to receiving specified services, usually inpatient care or surgery.

Primary Care Physician

A primary care physician (PCP) offers basic services or “first line” care. A physician or nurse-practitioner is usually responsible for the well-person and preventive care of plan members. A PCP also coordinates referrals to specialists. Specialists have specific training to treat health care needs such as major surgery or complicated cardiac care. Many plans now allow women to choose a gynecologist as a PCP for well-women care. Also, patients with certain types of chronic conditions, e.g. diabetes, may be permitted to have specialists as their PCP.

Provider of Health Care

Health care provider is a general term applying to any physician, clinic, or hospital offering medical services.

Quality of Care

Quality for a managed care plan is defined by nationally recognized standards of technical and interpersonal aspects of care. Appropriate services are those provided in the proper setting and a timely manner to the person in need.

Referral

A referral is a process used by a physician to arrange for additional health care services from another participating provider, usually a specialist, in a managed care network.

MEDICARE BASICS

For information on coverage, eligibility, enrollment, your Medicare Card, replacement card ordering, address changes, help with health care costs, and prescription drug assistance programs, please visit the Medicare Webpage at: www.medicare.gov/Basics/Overview.asp

Or call the Community Leaders Assisting the Insured of Missouri (CLAIM) program at 1-800-390-3330 or 1-573-893-7900.

[†]Many definitions on this page adapted from Managed Care Glossary 2000, Family Health Partners, Kansas City, MO.

Website References

Referenced Website Pages

These are websites referenced by number in the text:

- ¹ American Academy of Allergy, Asthma, and Immunology: Patient/Public Resource Center;
www.aaaai.org/public/default.stm
(800) 822-2762
- ² National Heart, Lung, and Blood Institute;
www.nhlbi.nih.gov
(301) 592-8573
- ³ National Institute of Diabetes and Digestive and Kidney Diseases;
www.niddk.nih.gov/health/nutrit/win.htm (800) 946-8098
- ⁴ American Dietetic Association;
www.eatright.org (800) 366-1655
- ⁵ American Cancer Society;
www.cancer.org (800) 227-2345
- ⁶ National Cancer Society;
www.mci.nih.gov (800) 422-6237
- ⁷ Gynecologic Cancer Foundation;
www.wcn.org/gcf (800) 444-4441
- ⁸ American Medical Association;
www.ama-assn.org
- ⁹ National Diabetes Educational Program
www.ndep.nih.gov
(800)-438-5383
- ¹⁰ Centers for Disease Control and Prevention
www.cdc.gov/diabetes
(877) 232-3422
- ¹¹ National Foundation For Depressive Illness, Inc.
www.depression.org/symptoms.html
(800) 239-1265
- ¹² National Institute of Mental Health
www.nimh.nih.gov
(301) 443-4513
- ¹³ Medline Plus Health Information Depression
www.nlm.nih.gov/medlineplus/depression.html

Other Useful Website Pages

The following websites may also be useful:

National Committee for Quality Assurance:

www.ncqa.org

Official Medicare -U.S. Government Site:

www.medicare.gov

HCFA's Medicare Compare:

www.medicare.gov/comparison

American Accreditation Healthcare Commission/URAC:

www.urac.org

Joint Commission on Accreditation of Healthcare Organizations/JCAHO:

www.jcaho.org

American Medical Association:

www.ama-assn.org

American Osteopathic Association:

www.aoa-net.org

Managed Care Central:

www.familiesusa.org/managedcare

American Association of Health Plans:

www.aahp.org

Health and Human Services
U.S. Government:

www.healthfinder.gov

National Health Information Center

nhic-nt.health.org

Missouri Pharmacy Association

www.morx.com

Plan Telephone Numbers and Websites

Medicare Managed Care Plans	Telephone Number	RN Hotline	Website Addresses
Advantra(GHP)	(800) 533-0367	(800) 580-9733	www.ghp.com
Blue-Advantage 65	(816) 395-3062		www.bcbskc.com
	TDD — (816) 842-5607		
Coventry Advantra	(800) 727-9712	(800) 622-9528	www.chckc.cvtty.com
HealthNet Senior Excel	(816) 460-4688	(913) 671-8730	www.healthnet-kc.com
Humana Gold Plus	(800) 448-6262	(800) 622-9529	www.humana.com
Kaiser Permanente	(800) 726-5247	(800) 870-5711	www.kp.org/locations/kansascity
Medicare Complete(UHC).....	(800) 656-0065	(877) 365-7949	www.uhc.com
Premier Plus	(800) 280-1602	(800) 811-1187	www.mercyhealthplans.com
St. John's Premier Plus	(800) 481-4466		www.mercyhealthplans.com
	TDD — (800) 446-1468		
Total Health Care 65	(816) 395-2525		www.bcbskc.com
	TDD — (816) 842-5607		

Missouri State Agency Phone Numbers

Missouri Department of Health

www.health.state.mo.us

Bureau of Health Care

Performance Monitoring (573) 526-2812

Missouri Department of Insurance

www.insurance.state.mo.us

Consumer Hotline (800) 726-7390

Kansas City Office (816) 889-2381

St. Louis Office (314) 340-6830

Managed Care-Jefferson City (573) 522-8767

Need More Information?

Please visit the Medicare Compare Website at:

www.medicare.gov/comparison

Concerns and Complaints

If you have concerns about your treatment or feel you have been denied health services, you may call your managed care plan. The plan will explain how to file a complaint and advise you of your grievance rights. If you disagree with a plan's position or decision, you can file a complaint with the Missouri Patient Care Review Foundation Beneficiaries Helpline at: 1-800-347-1016

The Department of Health expresses genuine appreciation to the following persons who assisted in making this report possible.

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You can get an up-to-date list of the Medicare managed care plans available in your area:

- ◆ By calling:
 1-800-MEDICARE (1-800-633-4227).
 For the hearing and speech impaired:
 TTY/TDD: 1-877-486-2048
- ◆ From the internet at:
www.medicare.gov.
 Your local library or senior center may be able to help you find this information on their computers.
- ◆ By calling the Community Leaders Assisting the Insured of Missouri (CLAIM) program. The number for CLAIM is: 1-800-390-3330.

Missouri Department of
HEALTH

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